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Disparities in access to maternal health care in Pakistan: poverty, gender, and social exclusion

POLICY RECOMMENDATIONS

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Social exclusion and Maternal Health: Policy recommendations

"Women are not dying because of diseases we cannot treat. They are dying because societies have yet to make the decision that their lives are worth saving." **(Fathalla, 2006)**

Currently, Pakistan's formal maternal health policy aims to provide skilled birth attendance with timely referral for emergency care in a well-functioning and well-funded health care system.[1] Yet, Pakistan is unlikely to fulfill its MDG no. 5 commitment to reduce maternal mortality by half by 2015 despite the implementation of these widely accepted best-practices. While there have been degrees of success, evidence suggests improvements in services has largely benefitted women in the highest wealth quintiles. For instance, while skilled birth attendance amongst the poorest wealth quintile did increase slightly from 3.5% to 14.9% from 1991 to 2007, usage amongst the highest quintile increased from 46.3% to 70.8%, thereby actually further increasing the inequity gap between the wealthiest and the poorest.[2,3]

The partial success of these interventions in reducing the inequities in maternal health services uptake raises the question of whether the current strategies are underpinned by an in-depth understanding of who exactly are the poor and socially excluded women in Pakistan. To date, identification of the 'poor' has simply been undertaken on the basis of economic assets using tools like the Pakistan Poverty Scorecard. However, poverty is multidimensional[4] and includes, besides economic poverty, lack of opportunities for education and a lack of social capital. Individuals or groups of people are poor because of social structures and existing power hierarchies that exclude them from access to resources and opportunities of all kinds[5]. The concept of social exclusion—the process through which individuals or groups are wholly or partially excluded from full participation in societies in which they live[6]—allows for a critical analysis of the relational aspects of deprivation and asks 'what are the social structures, processes and relations systematically deny some groups material and social resources?' In South Asia, the concept of social exclusion has been expanded to include perceptions of social identity related to caste membership.

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Zahida (below), a socially excluded woman who bled to death during childbirth due to financial delays in seeking emergency obstetric care

Rabia (left), a socially excluded woman bled to death giving birth to her son Bilal (below), now left motherless

Executive Summary

Table 1: Policy implications addressed

Recommendation	Problem/Question	Approach
A) Development of a more comprehensive and sensitive strategy to identify poor, socially excluded women	The poorest, most marginalized women are invisible and silent. They are not be easily identifiable. Poverty is stigmatizing and poor avoid being identified.	Maternal health interventions that aim to reach the poorest women need to use careful strategies to identify their target population. See possible indicators of social exclusion in Table 2.
B) Re-evaluation of maternal health strategies to take into account the unique vulnerabilities of the ultra-poor, socially marginalised women	Socially excluded women (and their families) are landless, lack education or access to stable income generating opportunities, often working in low-paying low status occupations. They are often bound in social contracts with higher land-owing castes. Their payments are often in kind, uncertain and not guaranteed.	Maternal health interventions must recognize that low caste, poor families are severely constrained in their ability to accumulate cash reserves necessary for seeking maternal health care, both in the public or private sector.
C) Development of novel and innovative methods of distributing poverty-alleviation benefits (such as BISP)	The poorest, socially marginalised women are excluded from formal government entitlements (such as BISP) through society's denial of their deprivation as well as through the mechanics of the distribution of poverty alleviation benefits.	Interventions that aim to transfer cash to the poorest women in support of better access to maternal healthcare will need to adopt a sophisticated understanding of who the poor are and re-evaluate the methods of identifying beneficiaries and develop novel ways of transferring the financial resources instead of relying on local authority figures (see table 2).
D) Education of healthcare sector employees surrounding their role in perpetuating social exclusion in the health system	The socially excluded women tend to be members of the *Kammi* caste. This caste is socially constructed as inferior and stigmatised. This then justifies their abuse, and exclusion, both by society generally and within state institutions such as the health care and education systems.	There is a need to challenge the stigma attached to the *Kammi* castes. A good place to start this challenge is within the health training and care institutional setting such as medical colleges, nursing schools, paramedical staff training institutes and in on-going professional development training.
E) Ensuring maternal health interventions are underpinned by an understanding of the current hierarchical social structures impeding progress	a. There is a widespread denial of the deprivation the *Kammi* people face by the upper caste members in the community, politicians, and bureaucrats. b. Improvements in the quality of services in the public sector has led to increased uptake of public sector services by the rich. The poor remain excluded.	a. Interventions intended to reach the poorest, most marginalized women must recognize that the social structures that perpetuate their situation are: 1)deeply embedded; 2) supported by an ideology that legitimises their marginalization; and 3)advantageous for the upper castes in the maintenance of the status quo. b. Interventions must be sensitive to the social barriers that exist between the providers and socially excluded women and their families and develop strategies to overcome them (see D above).
F) Enforcement of bonded labourer laws and the provision of resources to this population	The population of bonded labourers and their families working in brick kilns are completely excluded from even basic maternal and child health services as this population is not included in the community health worker catchment areas.	Acknowledgment of the existence of this population and the illegal nature of their positions as bonded labourers and the subsequent special inclusion of this population into provision of maternal health services must occur after identifying the extreme barriers faced by this unique population.

Note: Policy recommendations are not prioritized

A) Development of a more comprehensive and sensitive strategy to identify target populations

Traditional indicators of poverty are limited to material assets such as type of housing and ownership of items such as bicycles and TVs. While many of these indicators are informative and helpful, the subjective and robust local notions of poverty and exclusion must also be considered. Due to the invisibility of the *Kammi* caste members, large groups of women have been systematically excluded from receiving not only maternal health services but other poverty alleviation benefits as well.

Policy recommendation: Develop a set of indicators that include both effective objective indicators of exclusion and poverty as well as subjective local notions of exclusion and poverty.

Table 2: Potential indicators of poverty and social exclusion

Useful Indicators	Potentially Misleading Indicators
Individual's caste (*zaat or quam*) - Members of the *Kammi* caste are more likely to be socially excluded (see appendix). Castes can be identified by surnames.	**Rural/urban residency**. Not all rural residents are poor and not all urban residents are wealthy
Ownership of agricultural land	The **type of dwelling construction** or availability of amenities (such as a toilet) as in many cases, the ultra-poor are allowed to live in houses owned by the rich land-owners as payment in-kind. Some of these houses maybe *pucca*, well built houses, but is not reflective of the socio-economic status of the dwellers.
Ownership of land on which their house is built	**Ownership of the house if they do not own the land on which it is build.** Often *Kammis* are lent land (as payment in kind) to build their homes, but they be can be evicted at the whim of the landowner.
Occupation in the village (low caste occupations include butchers, barbers, carpenters, agricultural and domestic labour)	**Unemployment status of men** in the family. Many high caste men refuse to work in occupations they consider low status because doing so will comprise their and their *biradaris* prestige and reputations.
Type of remuneration for work done: Are they paid in kind or in cash?	**Whether or not they are officially enrolled in poverty alleviation benefit programs**
Women and children of the family working as agricultural labours on lands that do not belong to them or as domestic servants in other peoples houses	**Women who work on their family lands.** In households will small land holding women will work during planting and harvesting.
Work and residence in a *bhatta* (brick kiln).	**Who the villagers identify as poor** (the upper castes and elite villagers will usurp the conversation, will self-identify as poor while the true poor will not identify themselves for reasons of shame and stigma.

B) Re-evaluation of maternal health strategies to ensure the unique vulnerabilities of the ultra-poor, socially marginalised women are taken into account

As of 2008, the proportion of the labour force (adults, youth and children) involved in informal contracts in Pakistan is almost 30%, an increase of almost 10% since 2000.[7] Furthermore, 65% of these 'unpaid family helpers' are females; youth and children.[8]

Traditionally the lower castes, known as *Kammi* are economically linked to higher caste individuals in a social contract, locally known as the *seph* in Chakwal. The *Kammis* worked year round, performing agricultural and domestic tasks at the beck and call of the landowners. Their remuneration consisted of immediate, but small, cash payments and longer-term benefits including money for major expenses such as health emergencies. These entitlements were found to be informal and uncertain.

The dominant strategy of many current maternal health interventions is the promotion of saving money for childbirth (birth preparedness and complication readiness). The idea of saving for childbirth was well known among all castes within the village. Women and their families were aware of treatment and transport options should complications arise during childbirth. However, while higher caste and better off families could save significant sums, the poor, lower caste families did not have sufficient incomes that enabled them to save necessary amounts. Instead , they adopted the strategy of investing in their social ties with higher caste landowners in the hope that these people would support them in time of need. This is a risky strategy as discussed below..

There a 3 elements of the *seph*, the informal social protection mechanism that make it uncertain and consequently increases women's vulnerability: (1) There is no insurance guaranteeing its availability when needed and availability is dependent on the *wade log*'s kindness, financial liquidity, and mood; (2)when an adverse event happens, the *kammis* have to beg for the benefits they are entitled to. In the context of maternal health emergencies this can lead to delays leading to tragic consequences; and (3)the frequency of adverse events where the *wade log* are generally only willing to spend a certain, usually unspecified amount. A number of adverse events in a short period of time, the latter events may not receive funding from the *wade log*.

Policy recommendation: improve and develop program strategies addressing maternal health that take into account the social and financial constraints of those engaged in occupations that are paid in kind and not cash

The development of the doctrine of 'birth preparedness' and 'complication readiness' assumes that all members of society have the means to accumulate money and save for incidentals. Evidently, this assumption is excluding people who are paid in-kind, people who by being denied financial remuneration for their work have been denied of their ability to look after their well-being.

Novel and innovative maternal health strategies are needed which take into account the vulnerabilities build into informal labour contracts. Ideally, the elimination of this form of structural oppression would be recommended. However, these hierarchical social structures are resilient and require whole system changes that are outside of the scope of the current brief.

Kammi men from the *nai* sub-caste cooking for a wedding

C) New methods of distribution of poverty-alleviation benefits as a key factor in increasing poor and marginalized women's security

Two poverty-alleviation programs are currently on-going in Pakistan: the Benazir Income Support Programme (BISP) and the National Rural Support Programme (NRSP). The BISP is a social protection program aimed at subsidizing the ultra-poor's income. The NRSP provides microloans of 15-20,000 rupees to invest in an income generating opportunity. Both are being inequitably taken up by higher castes, those who need it least. Furthermore, the NRSP is being used for non-income generating activities like paying for weddings, funerals as well as home renovations.

The procedure by which BISP money is distributed is highly flawed. The 'poor' are initially identified and registered in a non-systematic manner via a poverty 'scorecard'. Members of the national and provincial assemblies were given a specified number of BISP application forms for onward distribution to the lowest administrative levels, the Unions Council Offices. As villages are typically run by local leaders from the highest castes and most prominent *biradaris*, this distribution ensured that recipients were selected on the basis of political patronism. For example, SS, a 50 year old retired army officer with a pension, a landowner, with two young sons working in a oil and gas company, was collecting BISP money on behalf of his old mother, a wife and two daughters in-law arguing that these women had income less than Rps 6000 per month. These examples were more common than not as in the list of 27 people in the village reported to be receiving funds. According to our observations and discussions, half of the current beneficiaries were not-poor. Most of the beneficiaries were upper castes misrepresenting themselves as 'poor', some falsely as widows.

Policy recommendation: implement an improved, sensitive strategy to distribute cash transfer programs which will eliminate preferential treatment for relatives and political connections.

What further exacerbates the entitlement of the higher caste members is that the most socially excluded (less excluded than the bonded labourers, of course) themselves carried no sense of entitlement that they should receive government benefits and even more, they could not even imagine that they could be entitled to these resources. Due to the stigmatizing nature of poverty amongst the lowest castes, they also were not comfortable declaring themselves as poor, whereas the higher caste villagers were self-identifying as 'poor' in order to collect these benefits.

Higher-caste landowners in the village

'A girl from the BISP survey team came to our house. She had no idea what she was doing. She just filled out the forms without understanding them. My wife told her that we have no TV...could she not see the big satellite dish on my roof.….women have a habit of lying. Now, when the girl saw the satellite dish on the roof, why would she not then ask "how come you don't have a TV but you have a dish?".' **(SJ, the largest landlord and politician of the village)**

D) Education of healthcare sector employees surrounding their role in perpetuating social exclusion

'This is how it happens, Shimraz's son was born in Sukhru (the Rural Health Center). Ask her what happened with her; how they dealt with her. They made her suffer. Like slaughtering a goat. This is how it happened. It is good for us poor people to use government hospitals, but government hospitals are butchers." (Kammi woman, 32 years)

A key socially constructed element of the *Kammi* identity was their inferior social status. Higher caste people frequently used derogatory terms to refer to *Kammis* and blamed the *Kammis* for their own poverty, citing their inherent caste-based recklessness, stupidity, and inability to manage their money. We found that *Kammi* women were treated poorly by government healthcare providers and were deeply distrustful of these services.

Policy-makers must recognize that healthcare organizations are not just mechanical structures that provide services but rather that they are systems that are culturally embedded and politically contingent, and that healthcare practitioners are 'purveyors of a wider set of societal norms and values'.[9] The technical upgrading of facilities may not benefit the poorest women if they continue to avoid using services due to poor provider attitudes and treatment. Furthermore, policy-makers must be alert to the ways in which well-intentioned interventions may inadvertently stigmatize and further disadvantage already marginalized groups of women. For example, the research team observed how the recently established government maternal mortality registration system had unintended negative consequences for the families of the dead women. During the fieldwork two maternal deaths of *Kammi* women resulted in visits by the district health office personnel to undertake a verbal autopsy. This unsolicited attention and questioning elicited fear and guilt among the family members.

Policy recommendation: incorporate continuing professional development education for health care professionals into criteria for renewing credentials that focuses on the role of the health care professionals in perpetuating poverty and social exclusion as well as their potential roles in alleviating poverty and social exclusion.

As well as educating medical professionals both during their foundational education and also at regular intervals throughout their professional careers on their role in the perpetuation of poverty and social exclusion, they must also be educated on their potential roles in alleviating poverty and social exclusion. Health care professionals are held in high esteem and therefore have a responsibility to utilize their skills and influence for sensitively promoting skilled birth attendance and reducing preventable maternal deaths.

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E) Ensuring maternal health interventions are underpinned with an acceptance of the current hierarchical social structures impeding progress

Twenty-five years of Safe Motherhood and later the Millennium Development Goal (MDG) initiatives, maternal mortality rates failed to reduce at rates in proportion to the amount of financial investment. For example, PAIMAN, a 10-district intervention between 2005-10 combined upgrading of health facilities with behaviour change and community mobilisation interventions, including a particular focus on 'birth preparedness' and 'complication readiness'.[3] This Intervention was found to increase levels of skilled birth attendance and postpartum care across all wealth quintiles, but not to decrease the differential between the rich and the poor. In terms of institutional delivery, no increase was seen among the poorest economic quintile, and in fact there was an increased disparity between the poorest and all other economic groups (being 17% versus 74% in the richest quintile post intervention).[3]

The results of our research have given an indication that not only is financial capital important but so too is social capital and those women in the middle and lower castes simply do not have the social capital to access quality services from government facilities. Unfortunately, caste in modern day South Asia has largely been 'swept under the rug', where nations deny the existence of a caste system and tout the effectiveness of policy and law that supposedly has eradicated the caste system.[10] Vatsyayan claims that 'where caste is mentioned, it is with embarrassment that it has yet to disappear in a secular and modern India' (p 104).[11] In Pakistan, the caste system has been subsumed and invisibilised in the discourse that Pakistan is a Muslim nation and therefore the caste system 'does not exist'. However, Mohmand and Gazadar[12] show in a national survey of the social structures in rural Pakistan the importance of the role of caste in daily life, as well as underpinning contemporary economic and political structures.

It is becoming increasingly clear that improvements in public sector services have not led to an increase in usage among the poorest. Rather, what is being observed is an increase in usage by the wealthiest groups. We argue that a key reason for this is that the poorest do not avoid the public sector because of a lack of standard biomedical services that are now in place for the most part, but rather because of social barriers, that include both the poor attitudes of the health service providers themselves (see page 6) as well as the increase in the number of 'elites' using the services which also exacerbates social exclusion.

If maternal health interventions are to make a real impact, maternal health policy must be underpinned by an understanding of the vulnerabilities the caste system imposes on certain groups of women and their families.

Policy recommendation: acknowledge the existence and role of the caste system in the perpetuation of poverty and poor maternal health outcomes and incorporate this into the policy underpinning maternal health strategies.

F) Enforcement of bonded labourer laws and the provision of resources to this population

The Supreme Court in Pakistan declared bonded labour illegal in 1988, an act passed in 1992 by the federal legislature (the Bonded Labour System (Abolition) Act and the 1973 constitution declared a ban on all forms of slavery.[13] The reality is that a blind eye has been turned to the resilient institution of bonded labour in the form of brick kilns.

The *seph* contract discussed above, where women, men and children work as 'unpaid family helpers' is not available to all low caste people. Work opportunities for marginalized people who do not have access to a *seph* are generally abusive of labour and human rights. One example of such industry in Pakistan are the *bhattas*. *Bhattas* are brick-making factories that are known to operate largely outside the law. The workers in these brick kilns are bonded labourers and once a family starts working in a *bhatta* it found itself forced into debt at interest rates the head of the families could neither articulate nor calculate the amounts he owed. To keep up with debt payments, men, women, old men and women and children as young as ten years old needed to work under unacceptable conditions from sunrise to sunset.

Although physically present, *bhattas* do not exist legally. The government does not provide basic services to those living in these brick factories, including routine primary health care services. *Bhattas* are not even included in the Lady Health Worker's catchment areas and our data show that no 'self-respecting' LHW would be willing to venture into a *bhatta*. The women and children who live in *bhattas* are completely excluded from all opportunities for receiving health care, including maternal health care which the state of Pakistan is responsible for providing to all of its citizens.

Policy recommendation: ensure legislation outlawing bonded labour is enforced and the provision of necessary resources provided in the interim as well as a strategy aid in the transitioning of this unique population from bonded labour to the remunerated labour force

The brick factory (above) where men, women and children (right) are working in illegal bonded labour

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Appendix 1:

Description of research project

Using a qualitative approach, the research was undertaken in a village in the District Chakwal in Northern Punjab from (put in dates). The research team consisted of 3 women and one man who all lived in the village for a total of 10 months, all of whom were trained anthropologists. The PI, an assistant professor from the University of Alberta's School of Public Health, also lived in the village for 3 months. Data were collected using social mapping exercises, demographic surveys, participant observation, formal and informal interviews, and focus group discussions.

The objectives of this research project were 3-fold:

- Identify, in precise detail, who are the disadvantaged and vulnerable women in Pakistan.

- Map the social relations of power and systems of 'interlocking oppressions' that create and sustain chronic poverty in some groups of people while privi-

The research team undertaking a social mapping exercise with women

Appendix 2:

Overview of caste in Northern Punjab, Pakistan

The village social structure was found to based on the traditional South Asian occupational hierarchy or caste system, which was further subdivided into extended family groups called *biradaris*. Five main castes (*zaat* or *quams)* were identified:

1) Chaudhrys *and Rajas* (highest)

2) *Mirzas*

3) *Miannies*

4) *Kammis* (lowest)

The focus of the remainder of this document is on the *kammi* caste as the social and economic hierarchies mirrored and reinforced one another, leaving the *kammis* the most socially and financially deprived. They traditionally performed low status occupations such as butchering or shoemaking, were largely landless, and lacked access to education and income-generating opportunities. The lowest sub-caste of the *kammis*, the *mussalis*, were found to perform the most menial tasks and hold a similar social status to dalits in India. Many of the *mussalis* engage in highly asymmetrical employment arrangements with the upper castes in a social contract called the *seph*. Here they worked year round, performing tasks such as planting and harvesting, collecting water, and doing domestic work. Their remuneration consisted of small but immediate cash payments and longer term benefits which included money for major expenses like maternal health emergencies. In reality, their entitlement to financial resources was highly uncertain and informal. Many who could not secure a *seph* would work at the brick factory where they received Rs 300 per 1,000 bricks and because this was insufficient to support their families, the families would borrow from the brick factory owners on an ongoing basis, incurring high interest debt which they could neither keep track of or calculate. This is illegal bonded labour that is a constitutional infraction.

Ultimately, *kami* women and their families are an invisible segment of society who have neither the financial nor the social access to uptake maternal health services.